BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RANDI M. GERMAINE, M.D.** Holder of License No. **21309** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-03-0897A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand & Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 10, 2005. Randi M. Germaine, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 21309 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-0897A after receiving a complaint from Respondent's employer alleging he overprescribed various medications leading to the death of a patient ("SB"). Respondent prescribed Darvon, hydrocodone with ABAB, OxyContin, bromazepam, Doxepin and other medications. Based on the calculations of the complaint, SB received 2,160 tablets of Darvon in approximately 180 days. This equates to approximately 12 tablets of Darvon per day with a recommended dosage of six tablets per day.

4. On behalf of the Board a medical consultant opined that the OxyContin and hydrocodone with ABAB prescriptions fell within prescribing norms if considered individually, but taken as a whole the total amounts prescribed could be considered excessive. The consultant also raised concern that Respondent did not have a pain management contract with SB.

5. SB's history included chronic pain syndrome, history of narcotic dependency, obesity, arthritis and migraines. Respondent last saw SB on June 20, 2003 and she died at the end of July 2003. The drug screen at autopsy showed Doxepin, Nortriptyline (there is no record of Respondent prescribing Nortriptyline), propoxyphene, bromazepam and alcohol in SB's system. A toxicologist with Arizona Poison Control provided an analysis of what the toxic levels mean. The most significant finding is the levels of Doxepin in SB's autopsy. Therapeutic levels of Doxepin are up to 0.115 milligrams per liter. SB's autopsy showed levels of 2.8 milligrams per liter, an amount that is almost always fatal and is most consistent with suicide.

6. Respondent testified that for the Board to understand what went on with SB they would have to know the history of what was going on in Morenci Healthcare ("Morenci") at the time. Respondent noted that, prior to his arrival, Morenci had a severe opioid-narcotic problem with their patients and the previous physician had been terminated precisely because he had very many high-risk patients on opioids who were abusers and users. The medical director also resigned and there were only three physicians and approximately ten physician assistants. Respondent testified that he was effectively left in control of approximately 150 to 200 people who were on opioid narcotics and, of these, SB was probably the most difficult of all the patients. Respondent noted SB became his sole responsibility.

7. Respondent testified Morenci hired David Greenberg, M.D. to help him with the prescribing problem. Respondent noted he and Dr. Greenberg went through SB's chart together and he made several recommendations. Respondent noted SB's grandchild had significant health problems and SB was often away dealing with this. Respondent stated Dr. Greenberg recommended Respondent discuss the case with a pharmacy consultant, refer SB to a pain clinic, obtain drug screens and counsel SB on weight loss, among other things. Respondent testified he followed all of Dr. Greenberg's recommendations. Respondent noted that when he took over SB's case she was and had been receiving 240 Darvon approximately every two to three weeks for several years.

8. Respondent testified he was unfamiliar with Darvon and had never prescribed it before. This is one of the reasons he consulted with Dr. Greenberg. Respondent noted that when he discussed this case with the pharmacist the pharmacist was unfamiliar with Darvon as well, but told him to go to a web site and look for side effects, etc. Respondent testified he did and reviewed it quite frequently. Respondent testified he also reviewed it with SB in detail. Respondent testified he knew SB very very intimately and had discussed all sorts of different things about drug addiction and various narcotics. Respondent noted SB had been to see several pain consultants prior and things just got out of hand. Respondent noted SB was not having any signs or symptoms attributable to Darvon.

9. Respondent testified he did have a pain contract with SB and the problem was she became very tolerant of all narcotic opioids she had been taking and in a matter of a few days they would no longer work for her. Respondent noted for some reason Darvon was the only thing that would work for SB, the only thing that would relieve her pain. Respondent testified SB told him she no longer wanted to live because of the pain.

Respondent stated his notes show he was clearly frustrated as her primary care physician and there is no question in his mind that after he left Morenci she committed suicide.

10. Respondent was asked if it surprised him that Darvon was the only medication that worked for SB. Respondent testified it did, but he was receiving approximately 150 new narcotic-opioid patients the vast majority of which were clamoring for OxyContin and different things like that, yet SB asked for Darvon. Respondent noted that in his mind Darvon was a very low potency opioid.

11. Respondent was asked to describe his practice before he went to Morenci. Respondent testified he spent approximately two years working in emergency rooms in rural Arizona followed by five years working at Concentra Medical Center doing occupational medicine and another year doing primary care. Respondent then went to Morenci to practice primary care. Respondent was asked how much experience he had in chronic pain management. Respondent testified he knew opioid medications very well, with the exception of Darvon. Respondent noted he had only sporadically had experience with Darvon and had never started a patient on it. Respondent testified he was more used to prescribing Darvocet that has acetaminophen in it for mild to moderate pain.

12. Respondent was asked to explain a refilling issue he had with the Morenci pharmacy. Respondent testified the pharmacy was 50 feet down the hall from his office. And he would often just walk to the pharmacist and discuss any problems. Respondent also testified he noticed the pharmacists were failing to put in the refills he had on several patients. For instance, because he saw SB so frequently he was putting in a refill on her Darvon and then she would return three weeks later saying she was out of Darvon. Respondent testified he would walk to the pharmacy and ask where SB's refill was and

discovered there was no refill in the system. Respondent testified he would then write a prescription and put a refill on it. Respondent testified he believes SB was taking the prescriptions to other pharmacies and filling them without Respondent's knowledge.

13. Respondent was asked why he simply did not ask the Morenci pharmacist whether SB had taken the prescription there and had it filled because that would explain why Morenci would not refill the prescription. Respondent testified it never occurred to him to ask the pharmacist if SB had ever presented the primary prescription. Respondent was asked if, once he realized the amount of narcotic that was being written for and filled and refilled, it occurred to him SB might be diverting or hoarding the medication. Respondent testified it did occur to him. Respondent was asked if he ever discussed these issues with SB. Respondent testified he did. The Board noted despite these conversations, Respondent continued to prescribe the medication.

14. Respondent was asked if he believed the doses he was prescribing were high. Respondent testified the doses were high from the moment he took over SB's case – that 240 every three weeks is already way above the limits. The Board noted Respondent's having taken over the case with SB already on high numbers of Darvon, but asked why he continued to prescribe this way rather than telling SB things had to be straightened out. Respondent testified if the Board looked at his notes when the consultations were made very early in his taking on the case it just took him a long time to get SB where he wanted to go. Respondent noted SB was very busy taking care of her ill grandchild.

15. Respondent testified he knew there was a problem with SB and he was extremely frustrated in the whole thing, but he did not have the availability of resources in Morenci to do anything else about it. Respondent noted he tried to refer SB to pain clinics and psychiatrists and SB flat out refused. Respondent was asked if he could have

refused to give SB any more medication. Respondent testified he could have. Respondent went on to note he diagnosed SB with pseudoaddiction – a pattern of drug seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction. Respondent testified there was no question in his mind that SB was in pain. Respondent added that SB did not fit the mold of a true addict – she came to see him with her husband and there was family involvement with her care

16. Respondent testified he doubted SB actually took all of the pills and that SB told him she dumped her OxyContin. Respondent also testified that SB's husband had taken some of her Darvon. Respondent stated that when he looks back at things, he may have been slow in reacting, but at the same time would say his treating SB for pain kept her alive. Respondent was asked to identify the underlying conditions that were causing SB's pain. Respondent testified that, according to the Integrated Pain Center diagnosis list, SB had degenerative disc disease, lumbar; lumbar radiculitis on the right side; trochanteric bursitis on the right; meralgia paresthetica on the right; arthralgias, diffuse; morbid obesity; hypothyroidism; and severe migraine headaches.

17. Respondent was asked if SB was seeing other physicians other than the referrals he occasionally made for her. Respondent testified that SB was and she also saw several physician assistants who would also prescribe. Respondent noted SB was not seeking prescriptions in a variety of places, but was shopping around pharmacies without his knowledge. Respondent also noted that one of the other things that made SB a problem was that there were three clinics he was working at that Morenci would have him go to. One was in Duncan, Arizona and one was in Safford, Arizona. SB would "pop into" both the other clinics and there was not good communication between the clinics and this led to some confusion.

18. Respondent was asked what he is currently doing in practice. Respondent testified he is working in Casa Grande, Arizona as a primary care physician. Respondent noted he tried to get back into a residency, but could not because of the complaint against him. Respondent was asked what his thoughts were when he continued to prescribe to SB even though he knew she shared her medications with family members. Respondent testified he told SB it was inappropriate for her to share her medications. Respondent was asked about the appropriateness of his continuing to prescribe while knowing SB was diverting the drugs to other people.

19. Respondent testified SB's husband was occasionally receiving the same drug anyway and he cautioned SB that it was a problem to share the medications, and that if it continued, he would stop prescribing. Respondent was asked if he felt it was appropriate to allow people to divert narcotics to others and, if not, what steps did he take to make sure it would not happen again. Respondent testified it was not appropriate and he cautioned SB about it. The Board noted that Respondent continued to prescribe for roughly two or three months. Respondent said his game plan for dealing with SB if she diverted again was to get her to the Integrated Pain Center and let them start taking over the opioid management. Respondent noted he believed the fact that he continued to prescribe for SB after she was thrust upon him as a patient is more of a reflection on the compassion he had for SB and he regrettably stuck his neck out for SB.

20. Respondent was asked how he avoids similar situations in his current practice. Respondent testified he is quick to refer patients out and it is not a problem in Casa Grande, Arizona to get people to see psychiatrists and pain medicine specialists. Whereas in Morenci, it was near impossible to get people to go over an hour for referred services. Respondent testified he has approximately 10 to 15 patients on opioid narcotics, long-acting. Respondent noted he did not start these patients on the narcotics,

but "inherited" them and he does not typically start patients on opioids for chronic pain. Respondent testified he has frequent consultations with the patients, employs drug screens, takes MRIs and x-rays of the patients, and has them all on pain contracts.

21. Respondent testified he wanted no part of the care of the patients on chronic opioids when he arrived at Morenci and these patients were thrust upon him. Respondent testified he believed his management did not significantly injure SB and that she was a pseudoaddict on the verge of committing suicide and needed psychiatric care, as noted by the pain specialist that saw her in April prior to her death. Respondent testified he repeatedly discussed the psychiatric issues with SB and tried to get her to see a psychiatrist, but she refused. Respondent noted SB had been on opioids since 1986 and any doctor that "inherited" her as a patient would have had a difficult time. Respondent testified he had left Morenci before SB died and another physician who took over her care also prescribed Darvon.

22. The Board's Chief Medical Consultant noted there was no pain contract in SB's records as reviewed by the Board.

23. The Board noted it did not believe SB's death was directly related to Respondent's treatment and the issues really revolved around excessive prescribing.

24. The standard of care required Respondent not prescribe excessive amounts of Darvon in conjunction with other narcotics to a patient with a diagnosis of chronic pain syndrome and a history of narcotic dependence.

25. Respondent fell below the standard of care because he prescribed excessive amounts of Darvon in conjunction with other narcotics to a patient with a diagnosis of chronic pain syndrome and a history of narcotic dependence.

26. SB was subject to potential harm because she could have become addicted and could have overdosed on the medications.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that

1. Respondent is issued a Letter of Reprimand for excessive prescribing.

2. Respondent is placed on probation for one year with the following terms and conditions:

a. Respondent shall within 90 days of the effective date of this Order obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in prescribing controlled substances and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of medical license. The probation will terminate when Respondent supplies proof of course completion satisfactory to Board Staff.

3. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of

time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 12 day of August, 2005.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By T C Miller
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 12th day of August, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by First Class Mail this
13th day of August, 2005, to:

Randi M. Germaine, M.D.
Address of Record